Kern County Children's Dental Health Network

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A partnership program between the Kern County Superintendent of Schools and West Kern Community College District

Dental Services Application

Contact Information

Pre/Elementary School _____ Principal Name _____

Address _____ School Phone # _____

City/Zip _____ Principal Email _____

School Nurse Name _____ School Nurse Email _____

School Nurse Phone _____ Fax # _____

School Contact/Coordinator: _____ Phone # _____ Email: _____

Name of Person Completing This Form

School Enrollment

Preschool - # of children enrolled ____ am ____ pm Classroom Hours - _____ am - _____ pm

Kindergarten- # of children enrolled ____ am ____ pm Classroom Hours - _____ am - _____ pm

General Information

Is your school on a modified calendar? ___ Yes ___ No (If yes, please attach school schedule)

What percentage of the children enrolled do you estimate will participate in the program? _____ %

Support

Do you have a room available for 3 days that can be used to provide dental services to the children ? ___Yes ____ No

Do you have a volunteer or staff person available to assist with escorting children to and from class? ___Yes ____ No

Completed Application

Please return this form via fax, email or US mail by **April 1, 2016** to:

Kern County Children's Dental Health Network, ATTN: Diana Baltazar (dibaltazar@kern.org)

1800 30th St., #230, Bakersfield, CA 93301

Phone (661) 377-0325 Fax (661) 377-0329

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